

Request For ACT-Approved Test Accommodations
Michigan Merit Examination (MME) - March 2008
Receipt Deadline: December 3, 2007

MI

This form is to be completed by a school official, such as counselor, special education teacher, or principal, following the instructions on page 2 of the Procedures for Requesting ACT Test Accommodations for Day 1 of the Michigan Merit Examination (MME).

A. STUDENT INFORMATION. (Please print or type.)

Student Name (Last, First, Middle Initial)	Date of Birth (Mo/Day/Yr)	Social Security Number (optional)
<hr/>		
Student Street Address or PO Box	City	State Zip
<hr/>		
Name of High School the Student Attends and Where the Student Will Test	ACT High School Code (required)	
<hr/>		
Name of Home High School (only if different from the school the student attends)	ACT High School Code (required)	

B. DIAGNOSED DISABILITY. Check all that apply.

Learning Disability (01)

- ☐ (DA) Developmental Arithmetic Disorder
☐ (RD) Developmental Reading Disorder
☐ (DW) Developmental Writing Disorder/Written Expression
☐ (LD) Other Learning Disability (explain on side 2, G)

Cognitive Disability (03)

- ☐ (AD) Attention Deficit Disorder/ADHD

Psychological Disability (03) NOTE: FULL DOCUMENTATION REQUIRED

- ☐ (AX) Anxiety Disorder (explain on side 2, G)
☐ (PD) Other Psychological/Cognitive Disability (explain on side 2, G)

Physical/Sensory Disability (02)

- ☐ (DF) Hearing Impairment
☐ (PH) Motor Impairment (explain on side 2, G)
☐ (VI) Visual Impairment (explain on side 2, G)
☐ (TR) Tourette's Syndrome
☐ (EP) Epilepsy or Seizures

Other Disability (07)

- ☐ (OD) Other (explain on side 2, G)
☐ (HB) Confined to home (explain on side 2, G)

C. TEST FORMAT REQUESTED. Check only one. Alternate formats must be supported by IEP or 504 Plan.

- | | |
|--|--|
| <input type="checkbox"/> (01) Regular Type (10-point) | <input type="checkbox"/> (07) Reader's Script* with Regular Type |
| <input type="checkbox"/> (02) Large Type (18-point) | <input type="checkbox"/> (08) Reader's Script* with Large Type |
| <input type="checkbox"/> (03) Braille (printed copy included) | <input type="checkbox"/> (09) Reader's Script* with Raised Line/Braille Tables and Illustrations |
| <input type="checkbox"/> (04) Cassette with Regular Type | <input type="checkbox"/> (19) Audio DVD with Regular Type |
| <input type="checkbox"/> (05) Cassette with Large Type | <input type="checkbox"/> (20) Audio DVD with Large Type |
| <input type="checkbox"/> (06) Cassette with Raised Line/Braille Tables and Illustrations | <input type="checkbox"/> (21) Audio DVD with Raised Line/Braille Tables and Illustrations |

Examinees using reader's script must test individually. Readers may **not read the tests to a group of examinees.*

D. TIME REQUESTED. Check only one. **ACT will assign a timing code (e.g., standard time, time-and-a-half, double time, triple time) based on the disability and approved test format.**

Standard Time (only for Regular or Large Type):

- ☐ One session with standard breaks between tests
☐ One session with stop-the-clock breaks
☐ Authorization to test over multiple days

Extended Time:

- ☐ All tests on one day
☐ Authorization to test over multiple days
☐ Extended time only on Writing Test (60 minutes)

E. OTHER ACCOMMODATIONS REQUESTED. Mark only if other accommodations are needed **in addition to** extended time or alternate formats (for example, authorization to mark answers in test booklet) and enclose supporting documentation.

☐ Other (be specific): _____

SUBMITTING THIS REQUEST: Incomplete or unsigned forms will delay processing, which may result in the student having to test without accommodations. The request **must** be submitted with a Test Accommodations Coordinator Header signed by your school's designated Test Accommodations Coordinator. Requests from your school should be sent as a group to: ACT State Test Accommodations - MI, 301 ACT Drive, PO Box 4071, Iowa City, IA 52243-4071. All requests must be received at ACT by **December 3, 2007**. Early applications are encouraged. If ACT has questions about the information submitted, the Test Accommodations Coordinator will be contacted.

Student's Name (please print) _____

Social Security Number (optional) _____

F. PREVIOUS APPROVAL OF ACCOMMODATIONS ON THE ACT. Check either "yes" or "no" to indicate whether this student has been approved previously for the same accommodations on the ACT.

- ☐ Yes If yes, complete all of Side 1 of this form and sign sections J and K. You may leave sections G, H, and I blank.
- ☐ No If no, both sides of this form must be completed and required documentation submitted.

G. DIAGNOSED DISABILITY. This is **required** and must be more specific than "learning disabled," "other health impaired," "perceptual communications disorder," "auditory processing deficits," etc. (For learning disabilities, check the psychoeducational report and other documentation on file at the school for a DSM-IV diagnosis and provide that if it is stated. If a DSM-IV diagnosis is not provided in any documentation now on file, state the specific characteristics of the student's impairment. If the diagnosis is not clearly stated, processing of the request will take longer and may require further information from the school before a decision can be made.)

H. HISTORY OF DIAGNOSIS. If first diagnosed before grade 9, complete only "age or grade of student" in section a. plus all information in section b. If first diagnosed *after* grade 8, all information requested in sections a. *and* b. must be completed.

When and by whom student was: a. **FIRST** diagnosed.

b. recently re-diagnosed (**within last 3 years**).

Date (month/year):

Age or grade of student:

Person making diagnosis:

Name/team

Job title(s)

*Qualifications (degrees,
specialization, certification)*

Note: COMPLETE DOCUMENTATION REQUIRED if FIRST diagnosed within last 3 years OR for visual, hearing, psychological, emotional, or physical disorder. (See "Guidelines for Documentation.")

I. CURRENT IEP or 504 PLAN ON FILE AT SCHOOL. The IEP or 504 Plan must state the need for extended time, alternate formats, and/or any other accommodations requested on Side 1 due to the disability listed above. If plan has been in place **less than 3 years**, complete diagnostic documentation is required.

1. Mark the appropriate box and attach the required copy (which must include student's name and effective dates).

- ☐ IEP; attach a copy of the test accommodations/services page(s) from the current IEP.
- ☐ 504 Plan; attach a complete copy of the current 504 Plan.

2. Mark **ALL** school years for which the student has had an IEP or 504 Plan, including year(s) before high school.

- ☐ 2007-2008 (grade 11) ☐ 2006-2007 (grade 10) ☐ 2005-2006 (grade 9) ☐ 2004-2005 (grade 8) ☐ Before grade 8

J. SCHOOL OFFICIAL'S SIGNATURE. *I affirm the student named on this form is enrolled at and/or attends this school, and I verify the information provided on this form and in the **attached IEP or 504 Plan and any other required documentation** is accurate, to the best of my knowledge, and reflects the testing accommodations now provided in school.*

School Official's Signature (may not be a relative of the student)

Print Official's Name and Title

School Official's E-mail Address

K. STUDENT/PARENT SIGNATURE. *I verify the information provided on this form is accurate to the best of my knowledge. I authorize the release to ACT of information related to this request by school officials, physicians, or others having such information, if requested. I understand that any documentation provided to ACT will remain with the application and will not become part of the student's permanent score record. If this request cannot be approved based on the information submitted, I understand the student may be required to test without the requested accommodations.*

Student's signature (**required** if 18 or older)

Parent/legal guardian signature (**required** if student is under 18). **NOTE:** School official may sign for parent/legal guardian only if verbal approval has been obtained by phone.

Date